NO BUTTS BABY

NSW GOVERNMENT Health
Illawarra Shoalhaven
Local Health District

Quit Smoking Service - Referral Form

CLIENT CONTACT DETAILS
MRN:
Name:
Address:
Phone:
Mobile:

TODAY'S DATE ……

ADDITIONAL CLIENT INFORMATION	
Best Contact Number	
Does anyone else in your household smoke? ❑ No ❑ Yes, if yes who? ……	
Have you tried to quit smoking before? ❑ No ❑ Yes If Yes, When was the last time you tried to quit? ……	
Is your home a smoke free zone? That is no-one smokes inside the home (visitors, household members) ❑ No ❑ Yes	
Estimate Due Date:	

REFERRAL SOURCE INFORMATION	
Name	
Position/Unit	
Do you want feedback on this referral? ❑ Not required ❑ Yes In what form? ❑ Email ❑ Phone call (provide contact #) ❑ In patient notes	

ANY OTHER EXTERNAL HEALTH CARE PROVIDERS?	
Medical practitioner (GP)	
Other	

Fax this referral to 4422 9684